ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PEDIATRIC/ADULT CYTOGENETIC (CHROMOSOME) TESTING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex **Gender Identity (optional):** ☐ Female ☐ Male ☐ _____

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Sample Type: ..... ☐ Peripheral blood ☐ Cord blood ☐ Buccal ☐ Skin Biopsy

Study Type

☐ Chromosome analysis (karyotype)

☐ Genomic microarray (aCGH)

☐ Chromosome analysis with reflex to microarray

☐ Newborn FISH panel (13, 18, 21, X, Y)

☐ FISH for specific condition (specify): _____

Indication for Testing (check <u>all</u> that apply—*required*)

☐ Suspected diagnosis of:..... ☐ Down syndrome ☐ Trisomy 18 ☐ Trisomy 13 ☐ Turner syndrome

☐ Abnormal prenatal cfDNA screening (NIPS):
☐ T21 ☐ T18 ☐ T13 ☐ Turner syndrome ☐ XXX ☐ XXY ☐ XYY ☐ Other (specify):

☐ Cardiac defect (specify): _____

☐ Dysmorphic features (specify): _____

☐ Multiple congenital anomalies (specify): _____

☐ Infertility

☐ Recurrent miscarriage

☐ Intellectual and/or developmental disability

☐ Autism/Autism spectrum disorder/Pervasive developmental delay (PDD)

☐ Learning disabilities

☐ Genital anomalies

☐ Ambiguous genitalia

☐ Partner with recurrent miscarriage (partner's name): _____

☐ Other (specify): _____

☐ Family history (complete information in box below)

☐ There is a family history of a chromosome abnormality in (relationship to patient): _____

☐ Confirm an abnormality *previously identified in this patient.*

IF EITHER OF THE ABOVE IS TRUE, to ensure correct testing, please provide:

1. The name/DOB of the previously tested family member (if not patient): _____
2. The abnormality found in the patient or family member: _____
3. **<u>A copy of the family member's/patient's previous test results.</u>**

For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141.

Master Label